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A Newsletter For Those Who Care For

ADOLESCENTS, ADULTS AND AGING ADULTS

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©A MEDICATION ERROR... WHAT TO DO NOW?

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Behavioral Objectives: After reading this newsletter the learner will be able to:

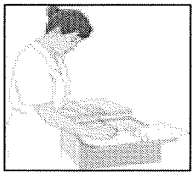
1. **Compare the 3 different categories of medication errors.**
2. **List the top priorities the healthcare provider should implement if a medication error does occur.**

Medical errors are a source of significant morbidity and mortality in healthcare settings across this country. Medication-related errors are one of the most common types of medical errors. A medication error is a preventable mistake in prescribing or administering medication to a patient, as well as the improper use of medicine or one that causes harm to a patient. Studies indicate that 57% of medication errors result in death or serious illness. Although medication errors don't always result in injury, as many as 7,000 patients, die each year due to medication errors. Thousands others suffer permanent harm.

Medication errors can occur at any point in the healthcare delivery system and in a variety of healthcare settings, including hospitals, outpatient clinics, nursing homes, during home care, as well in self-care. Acknowledging that medication errors happen, learning from those errors, and working to prevent future errors, is key. Every person on the healthcare team has a role in making healthcare safer for all patients.

MEDICATION ERRORS

Some medication errors are discovered before they reach the patient.



However, types of errors that do reach patients include administering the wrong drug, administering a drug to the wrong patient, administering an incorrect dose, administering a drug to a patient with a known allergy, administering a drug via the wrong route or technique, or failing to administer a dose. One study of more than 5,000 medication errors found that the most common types of errors resulting in patient death involved an improper dose (41%), the wrong drug (16%), and the wrong route of administration (10%).

The American Hospital Association lists the following as examples of common types of medication errors:

- *incomplete patient information (not knowing about patients' allergies, other medicines they are taking, previous diagnoses, and lab results, for example).*
- *unavailable drug information (such as lack of up-to-date warnings).*
- *miscommunication of drug orders, which can involve poor handwriting, confusion between drugs with similar names, misuse of zeroes and decimal points, confusion of metric and other dosing units, and inappropriate abbreviations.*
- *lack of appropriate labeling as a drug is prepared and repackaged into smaller units.*
- *environmental factors, such as poor lighting, heat, noise, and interruptions, that can distract health professionals when preparing and administering medications.*

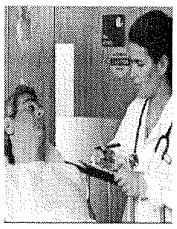
Studies suggest the increased hospital costs alone of preventable adverse drug events affecting patients are about $2 billion for the nation as a whole. But not all the costs can be directly measured. Errors are also costly in terms of loss of trust and satisfaction in the healthcare facility by patients, their families and the community.

Patients who experience a longer hospital stay or disability as a result of errors pay with physical and psychological discomfort. An often-ignored consequence of medication errors is their personal effect on nurses and the entire health care community. Nurses often feel demoralized and frustrated because they didn't provide the best possible care for their patients. Some nurses feel so emotionally devastated by an error that they become physically ill. Occasionally, nurses choose to leave the profession.

Healthcare professionals are vulnerable to error simply by virtue of being human. Moving away from the traditional healthcare culture of "naming, shaming, and blaming" individual health providers who make mistakes, is essential. This punitive attitude severely limits the reporting of errors. In fact, research shows that when the fear of punishment is removed, reporting of errors increases by as much as 10 to 20 fold.

WHAT TO DO NOW?

You discover that a patient's antibiotic IV drip infused at a significantly faster rate than ordered. Your facility requires you to report medical errors. But no harm to the patient occurred. What would you do?



If a medication error does occur, the patient's safety is top priority. Assess the patient immediately. Promptly notify the doctor of the error and the patient's status. Implement any ordered interventions and continue to re-assess the patient.

Once the patient is stable, report the incident to the appropriate authorities within your nursing administration, or according to your facility's policy.

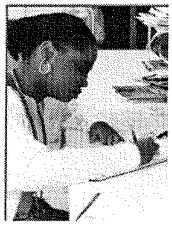
Improving patient safety begins with prompt reporting of errors, whether it was your error or one caused by a colleague. Such reporting is traditionally completed by filing an incident report. If you fail to make a required report, you may do more than increase the risk of injury to a patient—you may also jeopardize your own nursing license. However, healthcare professionals need to stop looking at incident reports simply as a document that provides legal protection after a medication error.

Incident reports should target medication errors in any or all of 3 basic categories—adverse events, "no harm events," and "near misses." It's good risk management to report all medication errors, including mistakes that don't cause obvious or immediate harm and near-misses. Say you discover that the pharmacist dispensed a dose in excess of what the physician ordered before the medication was administered. There's been no harm, but reporting it will enable your facility to learn why the mistake occurred and what can be done to prevent a similar error.

Anaphylaxis to penicillin clearly represents an adverse event. Intercepting the medication order prior to administration would constitute a near-miss medication error. By contrast, if a patient with a documented history of anaphylaxis to penicillin received a penicillin-like antibiotic, for example cephalosporin, but happened not to experience an allergic reaction, it would constitute a no harm event. In other words, when an error does not result in an adverse event for a patient, because the error was "caught," it is a near miss. If the absence of injury is owed to chance, it is a no harm event.

The incident report should be completed by the individual who witnessed, first discovered, or is most familiar with the incident.

An accurate, factual description of what transpired should be documented. Avoid making accusations about who's at fault. The name of any witnesses should be included on this report. The name of the employee directly involved in the incident can be recorded in the witness space as well, if the employee is not the reporter. The patient must be examined by an appropriate physician, who should complete the appropriate section on the form regarding his or her findings. The incident report should be completed no later than the end of the shift during which the incident occurred or was discovered to have occurred. Historically, error reporting has only been reactive, occurring only after an error has occurred. But reporting potential medication errors and near misses is proactive. This helps caregivers to prevent errors by identifying weaknesses in the medication-use process before a patient is harmed. Broadening the targets of incident reporting to include no harm events and near misses is advantageous to patient safety. These events occur approximately 300 times more often than adverse events.



The incident report is an administrative document, <u>not</u> part of the medical record. The fact that an incident report has been completed ***should not*** be reflected in the medical record, nor should the report be placed in the medical record. In addition, no copies of the incident report should be made. However, an objective description of the incident should be recorded in the medical record by both the medical and nursing staff, along with any follow-up observations, diagnostic studies and results, and/or related treatment.

Whenever a medication error or adverse drug reaction occurs, the JCAHO requires accredited healthcare facilities to conduct a detailed analysis of the incident. If the mistake causes a patient's death or serious injury, a so-called sentinel event, the facility is required to conduct a root-cause analysis. This aids in identifying the underlying cause and factors contributing to the incident. Additionally, a plan of action to prevent similar errors in the future, is recommended. This analysis should focus on how the error occurred, such as problems in the system and implementation, rather than on the error itself or the individual making it. This approach seeks to minimize the risk of medication errors by "fixing the system", as opposed to blaming the individual healthcare provider. The systems approach to error management has been a fact of life in aviation and nuclear power management for many years. For example, when an air travel incident occurs, the first question is not ***who*** caused the accident, but ***what*** caused it. In medicine, the systems approach has been slow to take hold. Perhaps it is because we don't want to believe healthcare professionals are fallible. We are trained to believe that perfect performance is not only expected, it is also achievable and that if we know enough, take enough care, and try hard enough, our patients will be safe and protected. The result is that we come to view errors as a failure of character, which it is not.

Not surprisingly, the blame-game approach to medication error prevention creates strong pressure for nurses to cover up mistakes, rather than admit and report them. Rewarding nurses with a 'thank you for reporting' goes a long way toward stimulating error reports. Managers, also, should follow up with healthcare providers about how their report impacted change.

Medication errors may cause serious effects, including death, or in fortunate cases they may cause no harm. They may also be caught before administered to the patient, and thus be "near-misses". Regardless of the situation, reacting appropriately is critical to patient safety and preventing future errors.

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